Art. XII.—*Notes of Hospital Practice.* By Henry Hartshorne, M. D.

In the wards of any well filled hospital, a great number of interesting cases must present under more favourable circumstances for the study of disease, than can usually exist in private practice. Under this idea I have prepared an abstract of notes, taken during the last two years in the Pennsylvania Hospital,—not in minute detail, but with a view in each case to some point of particular study. Where inexperience may have been mistaken in this object, and supposed that to be novel which to others is perfectly familiar, allowance must be made.

The irregularity with which different subjects are treated as to order of presentation, is of course the result of the manner in which all notes of actual cases must be taken at the different times when they occur. Some attempt at summary, however, will be made.

Case I.—*Empyema, with Perforation of the Walls of the Chest.*—Although the result of pectoral inflammation is certainly far from a common one, it so happened that three cases of it occurred in the hospital at the same period, during the service of Dr. W. Pepper.

The first, a German named Duerstein, aged about thirty, was admitted into the surgical wards (11th mo., 1845) for a fractured humerus. During his stay there, he contracted a severe pleuro-pneumonia;—which degenerated into chronic pleurisy with extensive suppuration. Being transferred to the medical wards, the case progressed in spite of treatment, producing emaciation, irritative fever and debility. After several months, the expectoration was observed to increase; and still later, with an extension of the dullness on percussion of the side affected (right side), a tumour began to be developed there, in the neighbourhood of the fifth rib. An alternation was then noticed between the amount of expectoration and the size of this tumour, which would perceptibly expand or lessen from time to time. Upon this fact, and the amphoric respiration at that part, Dr. Pepper founded the diagnosis, that a fistulous opening existed between an abscess in the pleural cavity and the lung. When this opening became obstructed, expectoration would be diminished, and the external swelling increased; and *vice versâ*.

4th mo., 1846. After the lapse of one or two months more, the swelling becoming larger, softer, and more painful, the treatment of it became an important question, But before any interference was decided upon, a small rupture of its surface occurred spontaneously, and the patient produced others with a pin in the night, allowing the exit of pus. Dr. Pepper then enlarged the orifice with a lancet. A gradual discharge of matter took place; his pain was nearly all removed, and all the symptoms ameliorated. Under iodide of potassium as a tonic and absorbent, and the use of morphia to allay cough, he continued better, although without much progress toward recovery, as long as he remained in the house, which was about three months more. The same alternation, however, between the external discharge and that by expectoration, continued with less inconvenience than before. When he left the house, he was able to walk, but was very thin, and still had a very troublesome cough.

Case II.—Bernard Turner, aged forty, had a fistula in his side when admitted. He was very feeble, emaciated, and with violent cough and night sweats. Of his previous history, we could only learn that he had been attacked with pleurisy more than a month before, which attack had become chronic; and that an abscess, pointing in his side, had been opened by a physician, thus producing the fistula. Examined carefully by Dr. Pepper 5th mo. 11th. He found dullness on percussion of the left side, both anteriorly and posteriorly—anteriorly with a well-defined limit between the third and fourth ribs; no respiration on the left side, exaggerated on the right. There was no sound to indicate fistulous communication between the lung and the pleura. The left side of the thorax was somewhat larger than the right. Dr. P. could not detect, with the probe, any opening into the pleura, although he supposed it probable that one existed. The discharge from the external orifice (which is at the middle of the left side anteriorly—over the sixth rib), is at present only a few drachms daily.

The diagnosis was, that pus existed in the left pleural cavity, from chronic pleurisy, without supposing that the lung and pleura communicated. The first treatment was with iodide of potassium, infusion of quassia, nourishing diet—with porter—and a cough mixture of morphia and syrup of tolu.

6*th mo.* 2*d.* His side has healed up,—but in his symptoms and general condition, there is little change. A few days after this, the iodide of potassium was stopped, and quin. sulph. and pil. ferri carb. substituted—continuing the other treatment.

17*th.* Has certainly improved steadily, though slowly.

7*th mo.* 11*th.* Does not retrograde. He went out of the house in the 9th month, in tolerable condition, but still with some cough.

He was readmitted 6th mo. 16th, 1847, for a pain in his side, but principally on account of the interest of his case. He had grown stout, and looked vastly better than he did a year before. The fistula had occasionally reopened, and discharged slightly for a short time during his absence,—but closed, finally, about eight weeks before his second entrance. Since its closure he had felt a sense of weight and pain in that side of the chest. Percussion is dull, however, only over a small space, and respiration only absent within the same narrow limits.

The pain was relieved, at first, by cupping and vesication, but returned and increased.

6*th mo.* 23*d.* A pouting as big as a marble, and fluctuating, was found over the site of the former fistula; this Dr. Pepper opened with a lancet, and a tablespoonful or two of pus escaped. The next day his pain had disappeared.

30*th.* He remains pretty well, and free from pain.

Case III.—Charles Logue had been ill for six months before admission, with cough from the first, of the exact pathology of which we obtained no medical information. He stated that a tumour of his left side had been opened by a physician about six weeks before we saw him. It had then discharged several ounces—the rest being "corked up" by the doctor for fear of weakening him, and allowed to pass off afterwards. His pain, and the harshness of his cough, were eased by the discharge.

The opening was near the sixth rib, below the cardiac region. It gave exit to a large amount of pus daily. He also coughed a good deal, spitting muco-purulent matter;—had considerable pain in the chest, and a slight diarrhœa. Treatment—quinine and iron, full diet, morphia cough mix-

ture, and afterwards p. opii et ipecac. in pill to check his diarrhœa. He appeared, at first, to gain a little strength,—but no essential change took place for some weeks, when the diarrhœa became worse, and aggravated his debility. He was removed to the almshouse; and, although living when we last heard, which was four or five months later, has, most probably, died a victim of phthisis.

Remarks.—In the first of the above cases, resulting from pleuro-pneumonia, there existed not only an external fistula, but also a communication between the lung and the cavity of the pleura. In the second, from pleurisy, we had no proof of any opening into the lung. In the last, of tubercular origin, extensive disease of both lungs and pleura, and the double fistula. In the last two, the opening was in the left side,—in the first, in the right.

The interesting point, with regard to them all is, the effect of *opening* the pleural abscess, when it projected between the ribs, forming an external tumour. In the consultations held over one of them, it appeared to be thought very doubtful whether an incision was proper, or even safe; an idea being entertained that perhaps the entrance of air under such circumstances might be deleterious.

But *à priori* considerations are really against this opinion; the adhesive inflammation which limits the traveling of pus within the chest, with such force as to compel a distension of the integuments, and the formation of a tumour, must certainly, even if the discharge did not prevent it, guard against any injury from the entrance of air. The real difficulty was to be certain in diagnosing the contents of the tumour. But all the appearances and signs, physical and rational, combined to favour the existence of suppuration. And the event of each case proved satisfactorily that the indication was, as pointed out by the efforts of nature, to *open it*. Exactly the same rules should apply to this, as to any other kind of abscess; when it becomes large, soft, and begins to fluctuate, and, by colour, makes known the approach of matter toward the surface, this should be facilitated, and the patient relieved by a careful incision. It is well known that some practitioners extend this treatment even to the management of phthisis, by perforating the walls of the chest, to evacuate a tubercular cavity in the lung.

Case IV.—*Recovery from Phthisis.*—A man named Evans, aged 27, was admitted in the fall of 1845, into the surgical wards, for a bad ulcer of the leg. He had then all the marks of confirmed consumption; emaciation, hectic, night-sweats, debility, severe and constant cough, with copious expectoration of pus, cavernous respiration, and dullness on percussion over the right lung.

He was ordered infus. prun. Virginian., good diet, and an opiate cough mixture, and the ulcer gradually reduced to a moderate size. It was then occasionally induced to discharge by a poultice for a few days—as he had noticed that when the sore had been nearly healed, his cough and general symptoms were worse.

Being transferred to the medical ward, the same treatment was continued for several months.

4th month 29th, 1846. He is now in good flesh and colour; has *no cough*, scarcely any soreness of chest even on breathing hard, no hectic nor night-sweats, and only a slight expectoration of puruloid matter. This, and very decided cavernous respiration and dullness on percussion over the right lung, are the only signs of disease left. The sore on his leg is now quite small, and discharges little.

5th month 4th. He leaves the house to-day in good case, the ulcer healed. We can consider this nothing else than a recovery from consumption, under circumstances of the greatest disadvantage.

Locality of Tubercle.—The rule which is laid down by authors, that phthisis attacks in preference the *left* lung, has met with many exceptions in our recent hospital cases. For several winter months, more than half of a considerable number of phthisical patients gave evidence of the disease in the right side. Nor was the *upper lobe always* prominently affected; although of this fact we had less opportunity of verification by autopsy, and the apparent exceptions to the rule were few.

Case V.—*Tuberculosis developed by Pneumonia.*—The history of a case was simply this. Thomas Galway, aged 30, was admitted with a complication of pneumonia with nephritis; as shown by all the symptoms and physical signs, under Dr. Gerhard's examination.

In the course of a month, the disease of the kidney gave way; but the pneumonia passed through the second and third stages—emaciation, hectic, and night-sweats supervened, and, finally, cavernous respiration, crackling, and profuse expectoration convinced us that phthisis was present.

He died about two months after the commencement of the attack. On post-mortem inspection, all the evidences of pneumonia were found in both lungs, particularly the left, in the middle and lower lobes. And in the most inflamed parts tubercles were seen, in the hard condition of recent formation, excepting one large cavity from softening, in the middle lobe. Dr. Wood concluded that the *pneumonia had developed* phthisis; because the tubercles coincided in situation with the inflammation, which was in the ordinary site of pneumonia, but an uncommon one for tubercle, unless when pervading the whole lung, as it did not here; and because the right lung, which had less inflammation, had also less tubercle. In both lungs, the upper part, where phthisis usually begins, was entirely healthy. The pneumonia was also evidently old, the tubercle mostly new.

Remarks.—The question whether inflammation ever develops tuberculosis, appears then to have an affirmative answer in this case. Authority would determine, however, that it is much less common than the reverse order of things.

Are we not, nevertheless, called by such a case to consider the occasional need of temporary *active* treatment for thoracic inflammation with acute symptoms, even in a person thought to be of a phthisical diathesis? There is perhaps too much opposition to moderate blood-letting, &c., in such instances. Although healthy nutrition is the great indication, yet it should be an even and tranquil nutrition, without any excess of stimula-

tion. And the stimulus of an actual inflammation must of course be the worst of all.

Internal use of Chloroform.—When the inhalation of this substance as an anæsthetic began to attract universal attention, we made at the hospital, at Dr. Wood's suggestion, some investigation into its effects when taken internally. Although very sweet, it is so pungent as to require a large proportion of gum water to obtund its effect on the tongue, throat, and even stomach.

Seventy-five drops gave me a sensation of general diminution of consciousness and sensorial capacity. Sight, hearing, and touch were all made less impressive, but no feeling of exhilaration or of derangement occurred. Drowsiness was positive. The pulse was not at all accelerated; in fact, it was two beats less in the minute. The same effects followed in two other medical gentlemen from two or three times the quantity. One swallowed a drachm, or over 200 drops. He became very heavy, and after a short interval went into a sound sleep. The effect passed off in all of us after an hour or two. No one felt exhilarated or deranged as by alcohol, and in none was the pulse increased. The conclusion was positive in all our minds that it is a *direct sedative* to the cerebro-nervous system—a sedative narcotic.

A woman who suffered with a most obstinate and painful neuralgic affection of the side and head, took 75 drops at night. She slept better than she had for weeks, even after inhaling ether or chloroform, as she had repeatedly; and was also unusually comfortable the next day. She then continued to take it, in a somewhat larger dose, for two or three weeks, every night; and improved under this more than under any other treatment.

From the pungency of chloroform I was induced to expect carminative powers. Upon trial in a number of cases of flatulent colic, I found it in the dose of 75 drops, sometimes repeated, to give prompt relief. It was then used as a substitute for Dover's powder as a soporific at night in rheumatism; and there answered admirably. There was but one patient, a woman with cancer of the uterus, to whom it was given as an anodyne, who alleged that it disagreed with her, causing headache and sickness of stomach without sleep or relief.

Believing it to be less constipating and more purely sedative than morphia, I tried the addition of it to cough mixtures in place of the latter. But here the objection presents, that so large a quantity of mucilage is required, as to oppress the stomach; or, if given in alcoholic solution, the stimulus of this vehicle might be undesirable. Still, as it is very pleasant to the taste, it might be added in small quantity to such mixtures, lessening the usual amount of opium in them.

It might be worth while to try it by enema in strangulated hernia, as a

powerful relaxant to the system generally, and at the same time an excitant of peristaltic action. It is our impression that it is somewhat laxative even when taken by the mouth; but our experiments did not render this certain. There is no doubt, however, that as a purely sedative narcotic and carminative, having the advantage of a sweet, pleasant taste, it might often be made a serviceable medicine.

ART. XIII.—*Further Observations on Trismus Nascentium, with cases illustrating its Etiology and Treatment.* By J. MARION SIMS, M. D., of Montgomery, Ala.

IT must not be disguised that there are cases of this disease, in which the displaced occiput cannot be rectified by any means whatever. The child is then born but to die, and will generally manifest symptoms of the disease at an early period; indeed, most frequently from the very hour of birth.

Before proceeding farther, it may be profitable here to take a brief retrospect.

1st. I have related cases, in which trismus nascentium resulted from an *inward* displacement of the occipital bone; that displacement being easily detected.

2d. I have produced facts showing that the same state of things may exist, when the displacement is so *slight* as not to be recognized, unless by a peculiar method of examination.

3d. I have adduced a series of cases, exhibiting the same characteristics, in a minor degree, depending upon the same mechanical agency; and relievable in the same speedy manner, which I have, for obvious reasons, denominated *trismoid.*

4th. I have produced cases to show that the displaced occiput will occasionally require surgical interference, before it can be properly adjusted.

Thus it will be seen, that the cases, so far adduced, are all of one general character; all go to show that the disease is the result of pressure exerted at the base of the brain; and in all this, pressure was produced by an *inward* displacement of the occiput, differing, however, in degree from the slightest to the greatest.

This brings me to the consideration of a class of cases, in which the disease was not the result of an *inward* occipital displacement, (and dorsal decubitus,) as in the foregoing, but was plainly caused by an opposite state of things—by a prolonged lateral decubitus, with a position of the occiput *exterior* to the parietal bones. This relative position of these bones is the only proper one in extra-uterine life. While my facts, so far,